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AUTHOR Pooley, Richard C.
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ABSTRACT

One of 52 theoretical papers on school crime and its relation to poverty, this chapter describes an interdisciplinary treatment program called the Pendleton Project. In this discussion, certain salient dimensions of the problem and its treatment are developed in some detail, namely, the diagnosis and treatment of learning disabilities and methods to establish attachment between the disturbing child, his family, and the social order in general. Strategies to extend innovation approaches to problem-solving are presented in the discussion of the practice of behavioral treatment and research activities associated with the practice. Topics include the community-based treatment of behavior disorders, theoretical considerations of delinquency, theoretical considerations of treatment, program development, and staff development. These topics are discussed in terms of principles of treatment, educational goals and deficits, short-term residential treatment, outclient treatment, and research associated with such treatment. Some conclusions are drawn that are likely to be useful to those interested in replicating the project. The sources used are previous research and literature on the subject and the personal observations of the author and associates. (Author/MLF)

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AN INTEGRATED, COMMUNITY-BASED APPROACH TO THE DIAGNOSIS AND TREATMENT OF DISTURBING BEHAVIORS SHOWN BY CHILDREN AND FAMILIES

Richard C. Pooley

A paper from
"Theoretical Perspectives on School Crime"

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ABSTRACT

The intention of this paper is to give a concise picture of increased disturbing behaviors shown by children (6 through 12 years old) and the cost of such behaviors in terms of dollars and human misery. It is suggested that certain diseconomies exist in the traditional approach to dealing with the problem and that innovation may be indicated. An example of innovation is an interdisciplinary treatment program called the Pendleton Project. In this discussion, certain salient dimensions of the problem and its treatment are developed in some detail, namely, the diagnosis and treatment of learning disabilities and methods to establish attachment between the disturbing child, his family, and the social order in general. Strategies to extend innovative approaches to problem solving are presented in the discussion of the practice of behavioral treatment and research activities associated with the practice. Topics include: (1) the community-based treatment of behavior disorders, (2) theoretical considerations of delinquency, (3) theoretical considerations of treatment program development, and (4) staff development. These topics are discussed in terms of (1) principles of treatment, (2) educational goals and deficits, (3) short-term residential treatment, (4) out-client treatment, and (5) research associated with such treatment. Some conclusions are drawn that are likely to be useful to those interested in replicating the project. The sources used are previous research and literature on the subject and the personal observations of the author and his associates.

Introduction

As those involved in the educational system of the United States will attest, disturbing behaviors, ranging from truancy and dropping out to more serious aggressive behaviors against persons and property, are on the rise among schoolchildren of all ages. It has been reported that, in spite of compulsory attendance laws in most states, more than 2 million of the nation's children are excluded from the educational process due to misbehavior of one type or another (Children's Defense Fund, 1974). Other reports indicate that schoolchildren with aggressive acting-out behaviors destroyed more than 500 million dollars worth of school property across the nation in 1975--a figure equal to the total annual amount spent on instructional materials. Furthermore, it is estimated that teachers are the victims of 70,000 physical assaults each year and that literally hundreds of thousands of students are assaulted as well. These figures were originally reported by a Senate Subcommittee investigating juvenile delinquency (Senate Judiciary Committee, 1975, 1976).

Professionals in virtually all fields of human behavior have addressed these problems in the context of scholarly research and, perhaps to a lesser degree, in that of action research directed toward the improvement of human service systems. These approaches appear to have raised more

questions than they answered. The bodies of knowledge in education, psychology, psychiatry, sociology, corrections, and social work are replete with theoretical positions and recommendations to solve the problems of living. Why, then, are disturbing behaviors increasing rather than decreasing? One reason may be the mass of conflicting information available in the behavioral sciences. We may be overwhelmed with seemingly plausible treatments that have not been proven effective in the natural environment. This flood of data may confuse some practitioners and render them less efficient. What appears to be called for is a very practical approach to problem solving. We must sift through the available information and experiment to discover those methods that consistently work where the problems actually exist, that is, in the natural environment. It is in this context that I shall discuss the treatment of antisocial behavior in children, together with some implications that are relevant to the prevention and control of problem behavior.

A Community-Based Treatment Project

The Pendleton Project is an interdisciplinary treatment program for children in trouble. Working in concert with nine human service agencies, the Project serves the localities of Chesapeake and Virginia Beach (610 square miles) in Southeastern Virginia. It is a community-based treatment center

directed toward reeducating children with behavioral problems, and their families, to decrease their likelihood of future maladaptive behavior.

Emphasis is placed on treating those behaviors that suggest antisocial development and that are likely to result in the need for some kind of intervention. The Project resources are designed to treat behavior disorders that may be a function of inappropriate learning or other deficiencies, sometimes called perceptual or learning disabilities or emotional adjustment difficulties. The Project's aim is to intervene where antisocial behavior exists, whenever reasonable and proper, early enough to prevent or reduce the probability of contact with juvenile justice, social services, mental health, or other human services. The organizational structure of the Project, together with descriptions of the diagnostic and treatment teams and their functions, are described in detail elsewhere (Pooley, 1975a).

The Project has developed diagnostic and treatment procedures directed toward making children in trouble and their families socially competent to function within the social order more effectively. They are taught ways to solve the problems of living.

In the past four years, the Project has served more than 900 children and families in trouble and has succeeded in diminishing the problem behaviors to acceptable levels

in 75 percent of the cases served (Pooley, 1976, 1977). As a result of this experience, we have distilled certain characteristics of the diagnostic and treatment processes that may be of general interest to those concerned with the prevention and control of problem behaviors in children and families. Before discussing the details of these operations, it is appropriate to address the theoretical underpinnings of the problem definition and treatment program development processes.

Some Theoretical Considerations of Delinquency

Children do not become antisocial overnight. The process is a gradual one and may have its roots in very early childhood. Sarbin (1952) presents a theory of self-development that defines five cognitive substructures which combine to make up the total Self or Ego. He suggests that, if the child is ignored, neglected, or mistreated during a crucial stage of development, he or she will probably not learn certain social skills. He proposes that, in delinquent boys, the cognitive substructure of Social Self is absent or poorly developed. This theory suggests that psychopathy is a variable that appears at various intensities (i.e., continuous), as opposed to being a binary variable, either present or absent (i.e., dichotomous). The intensity of the disturbance depends largely on the developmental experiences of the young person; it is not determined by any single event, genetic or

otherwise. The boy whose Social Self is absent will respond to certain stimuli with acting-out behavior. He has very little ability to defer gratification; he has not learned impulse control appropriate to his age. The boy with a poorly developed Social Self has some "time-binding" and "tension-building" skills; a kind of rudimentary conscience is apparent.

The psychopath suffers because he or she perceives, to some degree, that the external world or power structure has more power than he or she has. There is conflict with the external world, and this conflict is his or her undoing. Treatment may consist of teaching how to defy the external world and assert oneself through channels appropriate to the social order. The nonpsychopathic person probably learned such skills via developmental processes characterized by attachment to significant others. If this attachment is lacking, the development of the Social Self may be impaired. Adequate social development during the early years is probably prerequisite to what Alfred Adler referred to as "social interest." The person lacking social interest may not become competent in one or more of the "tasks of life," which Adler defined as love, work and friendship (Dreikurs, 1953). People who are inept at these tasks may not view others as potential reinforcing or supporting agents. As a consequence, they may have little regard for persons or property. People commit crimes because they do not care about others.

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One of the more prominent theories of why young people appear to "drift" into delinquency is that the American tradition of "deferred gratification" has lost potency among young people (Cohen, 1967). According to the control theory of delinquency presented by Hirschi (1969), people commit crimes because the bonds holding them to conventional morality, to personal accountability, and to interpersonal stability have broken down. Although few sources are mentioned above here, this assessment of the problem is consistent with recent reviews of the literature. Wenk (1974), reviewing more than 92 relevant publications, described the phenomenon of juvenile delinquency, particularly in the schools, as "... a crisis of human relationship, a crisis felt by millions but most visibily expressed by youth." Clarke (1974) cites 41 references in his analysis of previous work concerning goals and deficits of juvenile delinquency prevention and control programs. Several observations emerged from his study, among them that many of the programs appear inadequate in research design and that much money is spent on programs in total ignorance of results found in similar programs conducted elsewhere.

The above-mentioned positions on delinquency are certainly plausible and thus may serve as a reasonable set of assumptions upon which to base courses of action designed to prevent or control antisocial development in young people.

Theoretical Considerations for Treatment Program Development

The fundamental strategies chosen for the design of the Pendleton Project's treatment program are based largely on procedures that developed within the body of knowledge referred to as learning theory. The applied science derived from learning theory has certain advantages that can be exploited in a setting intended to correct behavior disorders. The associated literature describes 50 or 60 years of rather rigorous experimentation, and the procedures derived therein are easily understood. This gives us the distinct advantage of clarity. Our work has a point of departure that is clear and reliable.

Within the literature of human behavior, there is a body of research which stems from the work of B. F. Skinner (1953) and his associates and followers. It is referred to as the Experimental Analysis of Behavior. This approach to human behavior is concerned with a way of learning involving voluntary behavior, called operant conditioning. Operant behavior operates on the environment and is governed by specific consequences. Experimentation has demonstrated that the acquisition and maintenance of behavior patterns initiated by the subject are based upon processes which obey definable laws. Such behavior patterns are also, to a large extent, governed by their consequences. Thus behavior can be modified and controlled rather simply, once

the basic operations are understood. These operations are described thoroughly in an abundance of literature on the subject.

Essentially, the behavior in question is analyzed in the context in which it occurs. The analyst observes the conditions or events that are present just prior to the behavior--the antecendent events. He observes the behavior itself and records the frequency of its occurrence. The consequences of that behavior are then considered. Treatment may consist of altering the antecendent conditions to shape a new, more desirable bahavior, and/or changing the consequences so that the desirable behavior is reinforced or rewarded and the inappropriate behavior is not. Frequencies of the behavior are recorded before, during, and after treatment to determine the effectiveness of the treatment. When behavior frequencies do not change in the desired direction, the treatment program is altered and retested. Straightforward operant procedures have been used, for example, to eliminate fire-setting behavior in children by employing the stimulus satiation procedure described by Welsh (1971).

Sometimes undesirable behavior may be precipitated by emotional variables. We have eliminated phobic and avoidance response patterns using systematic desensation techniques based on the work of Wolpe (1973) and his associates. The theoretical premise here is that certain stimuli evoke responses in some persons who show conditioned

unadaptive habits or patterns of behavior. Treatment to overcome those habits uses such methods as counterconditioning, for example. Biofeedback has been used to reduce chronic anxiety and fear in children, and sometimes in parents. Biofeedback is an electronic method of providing the subject with auditory and visual signals that show the level and variance of certain internal states, such as muscle tension. The subject is instructed to try to alter the signal in the direction of lower tension levels. When this is accomplished, subject is reinforced. This process enables the subject to personally control level of muscle tension. He or she learns how to relax. Biofeedback has also been used to teach children self-control in order to reduce the frequency of temper outbursts and other forms of impulsive behavior. These methods will be described in greater detail later.

The effort to develop any program intended to address human behavior may borrow from the work already done in areas relevant to that program's specific needs. These needs will, of course, differ, and each practitioner must decide exactly what is called for and must search it out. To continue with the example of the Pendleton Project, I shall discuss some crucial areas of program development and some of the sources that we found to be particularly useful. The first step is to ensure that the treatment staff is competent to deliver the treatment of choice. This requires staff training prior to embarking on the treatment program.

Staff Development

By their very nature, interdisciplinary treatment programs employ people of diverse experience and training. This diversity must be formed into an integrated and workable pattern. There must be a common ground, on which all members can communicate, with respect to project philosophy and treatment planning. The study of human behavior offers an opportunity for such integration. After all, we are all human beings, therapist and client alike, and we all behave. Even here staff development is a gradual process, but most workers eventually come to realize that the behaviorist's point of view is virtually universal and that they can work with it without violating their professional and personal values. I have suggested some guidelines on the subject of training in another publication (Pooley, 1969). Tharp and Wetzel (1969) provide guidance with respect to outclient treatment as do Cohen, Goldiamond, Filipczak, and Pooley (1968) with respect to educational settings. Risley and Baer (1973) and Thoresen and Anton (1973) provide essential information that I have found excellent for staff basic training. It is sometimes desirable to contract with an outside expert to visit the project to conduct short-term staff training or to make recommendations for improvement.

Principles of Treatment

The resources that we draw from to design specific treatment programs are too numerous to mention. They are usually articles that appear in textbooks, professional journals, or technical reports. However, it is worth mentioning some that are basic to our treatment planning. Outclient treatment is patterned largely on the procedure outlined in Writing Behavioral Contracts (DeRisi & Butz, 1975). Essentially, this technique is intended to bring about behavioral changes with respect to the specific behaviors identified for treatment. Implicit in the method is to increase the frequency of positive transactions between the child and a significant other, such as a parent or teacher. Home-based reinforcement is often used. One procedure widely used at the Pendleton Project, wherein behaviors occurring in the school, such as "on-task behavior," may be rewarded in the home, is derived from the work of Bailey, Wolf, and Phillips (1970).

Our entire approach is governed by the positive or constructional approach to problem solving presented by Goldiamond (1974). The constructional method emphasizes the person's positive qualities and competencies and is directed to building on or increasing his repertoire of functional behaviors. We have frequently used two books in the coaching process intended to build skills in parenting.

They are Children: the Challenge (Dreikurs & Soltz, 1964) and Living with Children (Patterson, 1976; Patterson & Guillion, 1968; rev. ed. Patterson, 1976) The constructional approach to problem solving is also applicable to residential or day-care settings. However, residential treatment has been very much refined. This is possible because the controls available to the practitioner are greatly potentiated in a totally controlled environment, as opposed to the natural environment. Some outstanding work has been done to demonstrate and explain the precision with which residential and group-home environments can operate (Ayllon & Azrin, 1968; Cohen & Filipczak, 1971; Phillips, 1968).

It is important that we guard against the overuse of residential treatment for most acting-out children. Its use should be restricted to those cases where treatment in the natural environment is impossible. When residential treatment is used, it should be for as short a term as possible and should work toward establishing behavior patterns that are desirable and can be maintained by consequences present in the natural setting. We have found that in most cases this phase of the treatment can be completed in two to six weeks. Longer periods of residential placement are likely to cause dependence on the highly controlled environment; the ability to generalize the newly acquired behaviors may be impaired, and the child may become institutionalized.

Therefore, it is necessary to keep in mind the context in which disturbing behaviors occur. It is in this same context that the behaviors must be treated in order to ensure enduring effects. The problem of crime and other misbehavior among young people is not solved in the courtroom, in the detention home, or in a correctional or mental health institution. Such problems are solved in the community, in the school, or in the home. The behaviors we are concerned with are occasioned by these environments and that aspect of the problem must not be ignored. The acting-out child does not own the problem. The child has no problem, but is behaving according to what he or she believes will achieve certain goals. Society owns the problem. It is society who paid the 500 million dollars for property destroyed in the schools in one year. It is the social order that is responsible for decreasing the probability of such behavior in the future.

A child spends a good deal of time in school and at home. These two environments provide logical places to begin to investigate the causes of disturbing behaviors and to test out alternative corrective and preventive measures. The previous discussion shows that it is reasonable to assume that, if a child can experience success in school and at home, then the probability of continuing constructive growth is increased and his or her healthy and productive development is enhanced. Crucial to these developmental processes

are the bonds that hold the child to conventional morality, personal accountability, and stability. That is to say, the child's attachments to the family and to the social order in general should stay intact. With this in mind, we will next examine the potential of education, followed by a closer look at some variables that operate in the family and in other realms of the natural environment.

Educational Goals and Deficits

Education in this country is intended to be a constant source of supply of productive people, competent to address the problems of living in a responsible and constructive fashion. The object of the whole process is to improve the quality of life over time--not just for some people, but for all people. Unfortunately, some educators do not share this opinion; they have a much narrower view of the purpose of education. They believe that education should be restricted to academic subjects and that those not already motivated in this direction might just as well be excluded from the process altogether.

This simplistic view of education represents a serious diseconomy that this nation can no longer afford or tolerate. Remember, more than 2 million children are excluded from the educational process in a single year. Those excluded from a total education revisit us in vast numbers and in costly ways. Each year, this nation spends billions of dollars to process and maintain these people in courts and prisons,

on welfare and in mental health programs, and (if possible, and when the victims are sufficiently powerful) to repair the damage to persons and property left in their wake. The price tag on crime and juvenile delinquency alone is 88 billions dollars per year. It is clearly a situation where the old adage, "an ounce of prevention is worth a pound of cure," applies. But what is the ounce of prevention? Perhaps it is to refine our resources so that each child may receive, from the beginning, the education and/or other treatment required to develop into a productive human being.

This task is surely broader than academic achievement. It must include moral development, social development, and career development. The term "moral development" as used here does not refer to subjecting children to one or more religious beliefs, but rather to educating the child in matters of conflict resolution and decision making in ways derived from the notions of Piaget (1965) and Kohlberg (1971). This approach stresses the importance of deliberately developing decision-making skills. This is done by encouraging the child to become competent in problem solving, so that he or she may organize and understand the experience and solve the problems of living (Rest, 1974). "Social development" as used here refers to teaching the child social skills that increase competence in transactions with others. It also gives the child the ability to "read" the social order more accurately and thus to respond to it in an acceptable and successful manner. Recent surveys of school

populations show that children wish to receive more information about career fields. They wish to become better informed concerning their options and the requirements attached to pursuing particular careers. Fortunately, there is an interest on the part of some educators to respond to this need (Benson, 1975; Tennyson, Hansen, Klaurens, & Antholz, 1975).

No matter how excellent the quality of general education may be, there will always be a need for special education. Some children simply have learning deficiencies that must be corrected in special environments. One area of special education is intended to correct what is referred to as "learning disability." This is an excellent example of the unnecessary confusion to which some disciplines fall victim. Let us take the example of a single learning disability called "dyslexia." Apparently, dyslexia has something to do with difficulty in learning to read. But some professionals insist on spending their time arguing about exactly what dyslexia means in terms of behavior, rather than in developing ways of teaching the children to read. In a seven-year period, more than 20,000 books, articles, and papers have been published on the subject. Learner (1971) summarized the situation as follows:

> The National Advisory Committee on Dyslexia and Related Disorders was created by the Secretary of Health, Education, and Welfare in 1968 to investigate, clarify, and resolve the controversial issues surrounding dyslexia. The Committee report,

> released by HEW in August, 1969, reported the following information about dyslexia: "In view of these divergencies of opinion, the Committee believes that the use of the term 'dyslexia' serves no useful purpose" (National Advisory Committee on Dyslexia and Related Reading Disorders, 1969, p. 38). Perhaps more important, however, the report recommended to the Secretary of the Department of HEW several vital steps to improve the reading of students within our nation who experience difficulty in learning to read. One of the key recommendations was the creation of an Office of Reading Disorders within an appropriate agency of the Department of Health, Education, and Welfare. (p. 187)

Some eight years later, HEW has proposed regulations setting up procedures for diagnosing children with specific learning disabilities. Unfortunately, the proposed regulations seem tentative because HEW conceded it could not get experts to agree on exactly what constitutes a specific learning disability (Differing Views Snag HEW, 1977). So the beat goes on.

Learning problems are of particular interest to those concerned with crime in the schools because there is growing evidence that the majority (60 to 90 percent) of adjudicated youth and adults have identifiable learning disabilities. In our project alone, 66 percent of the children referred to us for behavior problems have diagnosed learning disabilities, whereas only about 15 percent of the total public school population in our region are identified in this way.

The Pendleton Project's treatment methods are very logical and direct. Happily, some of the 20,000 publications mentioned earlier are very useful in diagnosis and treatment.

We have borrowed from the inspired literature to address the problem. Rather than becoming distracted by attempting to name the dysfunction, we concentrate on what the child cannot do and, more importantly, on what he can do. We expand his skills from his existing relevant repertoire. Hobbs (1975) states, "in practice, the term learning disability is used to imply a handicapping condition associated with the inability of a child to perform school tasks at a level expected of him" (p. 79). Using this as a point of departure and ruling out all physiological explanations for the problem (bsed on the appropriate examinations when indicated), we proceed to close the gap between performance and expectation in a systematic, step-wise manner.

Short-Term Intensive Treatment of Behavior Disorders

The majority of children referred to the Pendleton Project are successfully treated with the use of behavioral contracts that are negotiated between the child and significant others, such asparents and teachers. This treatment will be discussed in detail later. Briefly, these cases are treated in the school and the home and are not selected for short-term intensive residential or day-care treatment. However, about 15 percent of the people referred to us can benefit from the "intensive-care" approach. This treatment is conducted in residence over a period of from two to nine weeks, whereupon the child is returned to the school and

home with a set of recommendations for actions that were tested and found to be effective in establishing and maintaining appropriate behaviors.

The diagnostic procedure has several decision points that will ultimately determine the treatment that is administered to the child, the parents, and the teachers. The diagnostic team considers each case within an "if so, then so" context. Information such a IQ scores and existing psychological or educational evaluations are collected. Behavioral data are generated on the daily or weekly frequencies of the behaviors to be treated. These data are maintained throughout treatment as a record of the treatment program effectiveness. When desired results are not shown, the program is altered. With these data at hand, we may proceed through the decision-making steps.

If the subject exhibits behavior problems that are too severe to be treated in the natural environment but does not show evidence of a learning deficiency (such as discrepancy between expected functioning and performance on academic tasks), then he or she is placed in the residential school for a short stay. This environment uses vigorous behavior management and other therapeutic procedures to bring the problem behaviors under control and to replace the disturbing behaviors with appropriate ones.

If the history of the child indicates that a learning disability may be present, then a full assessment of the

potential problem is made. If the subject is found to have a learning disability, then he or she is placed in the project's Prescriptive Learning Center for at least two hours a day. The remainder of academic training is done in the classroom. A resource teacher monitors progress and prescribes appropriate educational materials and procedures.

The majority of children referred for residential treatment have difficulty with reading. This academic deficiency will be used to illustrate our discussion of the diagnostic/prescriptive process. The purpose of testing is to determine the child's current level of functioning with respect to academics and also to estimate his or her potential in these areas. Testing may indicate the child's strengths and weaknesses and identify the probable causes for a deficiency, if and when one exists. The child may be observed while being tested so that any behaviors relevant to the diagnostic process can be specified. The purpose of this process is to determine the child s preferred learning mode and to specify the most compatible materials and teaching techniques.

The characteristics measured may include intelligence, communication skills, visual and auditory performance, and academic achievement. The results of the tests provide diagnostic information in three major areas of learning: conceptual functions, perceptual functions, and sensory motor functioning (Walsh, Serafica, & Bibace, 1976). It is

notable that Walsh, et al. (1976) state that, if communications between the referring teacher and the psychologist are explicit. then it may not be necessary to test the student exhaustively or at all. Teacher observations of the student's performance, stated in behavioral terms, are often a highly reliable assessment of the learning difficulty. When such assessments are available, the remedial teaching strategy can be implemented in the absence of standardized test results. When clear behavior statements concerning what the child can and cannot do are available, then some testing may be necessary to pinpoint the specific functions in need of improvement or retraining. Some of the test instruments used by the Pendleton Project, together with the characteristics that they measure and their sources are shown in Table 1.

If the Performance IQ score is lower than the Verbal IQ score of WISC-R, concurrent with weak Frostig Visual Perceptual Test results, then Bender Gestalt Visual Motor Test is recommended. If Verbal IQ score is lower than Performance IQ score, then ITPA is recommended (Walsh, et al., 1976).

If the learning disability is identified as a reading disability, then the student will receive remedial prescriptive services from the Prescriptive Learning Center within the project. When a program is designed, tested for a few

Table 1

The Pendleton Project Testing Options for Reading Diagnosis

Diagnostic/prescriptive area	Test Instrument	Source
Intelligence	Wechsler Intelligence for Children Revised (WISC-R)	Psychological Corporation
	or	
	Stanford-Binet Form L-M	Houghton-Mifflin
	or	
	Peabody Picture Vocabulary Test (PPVT)	American Guidance Service, Inc.
	or	
	Slosson Intelligence Test (SIT)	Slosson, Ed., Publishing
Development and Communication; Specific Visual and Auditory Problems	Illinois Test of Psycholinguistic Abilities (ITPA)	University of Illinois Press
	Goldman, Fristoe, Woodcock (G-T-W) Auditory Test Battery Skills	American Guidance Association
	or	
	Marianne Frostig Developmental Test of Visual Perception	Consulting Psychologists Press
	or	
	Bender Visual Motor Gestalt Test	American Orthopsychiatric Association, Inc.

Table 1 continued

Diagnostic/prescriptive area	Test Instrument	Source
Achievement	Peabody Individual Achievement Test (PIAT)	American Guidance Service
	or	
Aptitude	Detroit Tests of Learning Aptitude	Bobbs-Merrill Company
Reading	Durrell Analysis of Reading Difficulty	Harcourt, Brace, World, Inc.
	or	
	Woodcock Reading Mastery Test	American Guidance Association

weeks, and found to be workable, the child is returned to the public school with recommendations designed to maintain the acquired positive behaviors, together with a plan designed to maintain a high probability of continuing academic progress. A task analysis will pinpoint basal entry level with reference to instructional materials for the remediation. The compatibility between the child's most efficient learning modality (auditory, visual, or multisensory) and the remedial material best suited to a particular teaching method is specified as well. Audio Reading Laboratory materials (Sanford & Crosby, 1975) and audiovisual teaching machines such as Craig Reader and Language Master are preferred to traditional printed matter. However, the Sullivan Reading Program (Buchanan, Dodson, Huntsberger, & Russell, 1973) sequentially presented reading material is sometimes used at the project. MWM Program for Developing Language Abilities (Minskoff, Wiseman, Minskoff, 1972) is an essential remediation kit of workbooks and activities correlated to remediate subtests of the ITPA.

Psycholinguistic ability is closely related with reading, listening, and other language abilities. The Social Skills Development Program at the project is designed to increase competence in communication skills. A variety of oral communication drills or behavioral rehearsals are used to accomplish this task. The Therapeutic Recreation Program serves to sharpen sensory-motor functions and may

serve to augment the student's visual-motor functions as well.

Criterion-referenced and norm-referenced tests are used to measure individual improvement and program effectiveness. The results provide guidance to decision making in prescription and in the refinement of treatment programs.

Sometimes the child is not succeeding because of emotional disorders rather than because of a learning disability. If behavioral observations suggest that this may be the case, then the Children's Apperception Test (CAT) or Rorschach Test (ink blots) may be administered. If the test results confirm the hypothesis, then the project recommends that the child be placed in a special education environment within the public school designed to educate children who are distracted as a result of emotional concerns. Prior to this, we may treat some emotional disorders in order to reduce certain stimulus effects.

A subset of our treatment population is that of the anxious child. Certain stimuli may evoke high levels of anxiety or fear in children which are likely to result in impulsive acting-out behaviors such as tantrums, verbal aggression, or fighting. Often the stimulus which increases anxiety is the child's inability to accomplish some task such as school work. Other children are characterized by nonspecific, or "free-floating," anxiety. It is tempting to speculate that this type of anxiety is associated with

a generalized fear of failure. There is some evidence to support this view. It is ironic that many of these children fail constantly, yet rarely seem to adjust to or become desensitized to repeated failure. Even after the child learns to succeed, the anxiety remains. Pre- and posttest results on self-concept have shown that some children who have received conventional residential treatment at the Pendleton Project improve significantly on all subscales of the Piers Harris Children's Self Concept Measure except those subscales that measure "Anxiety" and "Happiness & Satisfaction." Anxiety appears to be the trait that is most resistant to treatment.

In order to address this problem, we have included in our treatment program methods used by Joseph Wolpe and his associates. I refer particularly to the procedure of counterconditioning that is based on the principle of reciprocal inhibition; namely, "If a response inhibiting anxiety cam be made to occur in the presence of anxiety-evoking stimuli, it will weaken the bond between these stimuli and the anxiety" (Wolpe, 1973). The child is first trained in progressive relaxation (Jacobson, 1938). When this technique has been mastered, the anxiety-producing stimuli are presented in a hierarchical fashion, starting with the least disturbing stimulus and continuing through stimuli that are more and more potent in producing the anxiety. At each step, when anxiety begins to occur, the

subject is instructed to relax in accordance with this previous training. This relaxation provides the anxiety-inhibiting response in the presence of the anxiety-evoking stimulus. Eventually, the subject does not become anxious in the presence of such stimuli. The levels of anxiety can be measured by verbal report on the part of the subject or with the use of biofeedback equipment. We have used both methods with encouraging results.

I have chosen to describe the treatment of reading difficulties in some detail because most acting-out children who are referred to us have reading deficiencies. Such a deficit may be a function of intelligence or of perceptual or emotional variables. The discussion serves to illustrate the climate of the organization and its attitude toward problem solving. Our approach is step-by-step treatment directed to treating the whole child in a constructive framework that spans all areas of the child's experience, including academics, recreation, social development, and career awareness.

All the children referred to us are showing some disturbing behavior. These behaviors are analyzed and treated, and procedures designed to eliminate the disturbing behaviors and replace them with competence are established prior to any recommendations to others. This can sometimes be accomplished in two weeks; often it is accomplished in four to six weeks. We concentrate on learning and social competence because it has been demonstrated by our Project and

elsewhere that when a child can succeed in school, he or she is unlikely to misbehave (Allyon & Roberts, 1974).

There is no mystery in the process of prevention and control of problem behaviors in most children. The treatments for behavior disorders are clearly understood and documented. This is not to say that the task is easy. It is often very difficult and always requires treatment agents who are dedicated and rigorous in the application of technique. After treating more than 800 children and families, we have found, as have others, that a key determinant to the success of behavior treatment is the degree to which the recommendations made by the behavior analyst are followed in the natural environment. If the recommendations are followed, then the treatment is likely to have enduring effects. If the recommendations are not followed, then the subject is almost certain to revert to his or her former style. This does not mean that the recommended procedures must be carried out forever. It means that the treatment procedures must be phased out gradually if the treatment is to have enduring effects. During this fading process, the subject learns to respond favorably to the natural consequences of the courses of action characterized by competence that he learned during the treatment process.

In order to provide environments that sustain socially appropriate behavior, perhaps we must reorder some of our priorities. It has already been demonstrated that the ability to learn is related to behavior. It has also been shown that

most children who act out with disturbing behaviors do not learn as easily as their "well-adjusted" counterparts. The methods to correct the situation are clearly understood. The problem is that the arenas available to deliver this service are in short supply. This nation simply does not strongly endeavor to ensure the healthy academic, social, and moral development of all its children. It would appear that we prefer to wait until children commit serious offenses so that they can be incarcerated to working to prevent this outcome in the first place. The national price tag on crime and juvenile delinquency is 88 billion dollars per year. Expenditures for public elementary and secondary education were less than 62 billion dollars last year and considerably less than that in preceding years.

I believe that the children who are not given adequate educational opportunity and social nurturing somehow understand what is happening to them. I believe that they resent the social order for this negligence and they are showing their resentment in the only way they know--with aggression.

This brings us to the consideration of the most pervasive treatment arena--the natural environment.

Interdisciplinary Outclient Treatment of Disturbing Behaviors

The task of the Pendleton Project is to reduce problem behaviors in young children, 6 to 12 years of age and their families, to enable them to function in the future without continuous or intermittent intervention from human service agencies. Besides dealing directly with children and families, we have assembled and maintain a regional interdisciplinary organization to ensure a coordinated human service delivery system during the course of treatment. This organization covers a relatively large region (610 square miles), within which are two independent municipalities. Each city has five human service agencies which participate in the Project by assigning one employee (i.e., social worker, probation officer, educational specialist) to serve on the outclient treatment team. Thus we have 10 human service agencies in two cities spread over a large area, and a residential school staffed with teachers, counselors, behavior technicians, cooks, maintenance men, administrators, and support staff.

One might conclude that such an organization could be difficult to manage. It is initially difficult to manage such a group, but it is not impossible. It is not my purpose here to describe in detail the organizational structure, as this information is available elsewhere (Pooley, 1975a). The purpose of this section is to describe the process of

outclient treatment. Residential treatment is mentioned during this discussion because it was used prior to the final phase of establishing treatment in the natural environment in about 15 percent of the cases served.

Principles of Outclient Treatment

We have fashioned our approach on the methods presented by Tharp and Wetzel (1969). These methods center on the technique of contingency management, which the authors define as "the rearrangement of environmental rewards and punishments which strengthen or weaken specified behaviors." Or, more precisely:

> The task of contingency management comes to be the reorganization of the patterns of reinforcement control exercised by people of an individual's environment. The task of the contingency manager in the complex social environment is thus to specify the correct pattern of reorganized control, and to modify the behavior of the controlling people so that they will correctly reorganize for the ultimate benefit of the deviant individual. (p. 3).

This method is useful in controlling the behavior of the organization delivering the service as well as that of the deviant individual. The treatment sequence is a chain of contacts from expert technicians (in short supply) to treatment agents (available in greater numbers) who ultimately deliver the treatment to the subject or "target." The treatment chain is supervising psychologist→behavior analyst→mediator→target.

The supervising psychologists are people highly trained and experienced in the principles and techniques of behavior analysis and treatment. As they are in short supply, it is most efficient to use their talents to coach or train others. The supervising psychologist may rarely or never see the targets.

The behavior analysts receive direct guidance from the supervising psychologist. The object of this relationship is to pass on the skills possessed by a single psychologist to several behavior analysts, who will in turn train or coach several mediators.

The mediators see the deviant individuals every day, or at least very frequently. Parents, teachers, siblings, friends, or volunteer workers, such as Big Brothers or Big Sisters, may serve as mediators. With the guidance of the psychologist, the behavior analyst analyzes the problem and designs the treatment program. The behavior analyst coaches the mediator in the treatment of choice and oversees the practice of that treatment until the mediator can carry on alone.

The target is usually the disturbing individual or the child who was originally referred for treatment. However, this is not always the case. Sometimes the behavior analysis reveals that, although it is the child who is visibly misbehaving, the root of the disturbance lies elsewhere. For example, a parent or teacher may be the disturbing

individual and the child may be reacting in a similar manner. In such a case, that individual becomes the primary target, whereas the child becomes the secondary target for treatment. Nevertheless, the chain of treatment, supervising psychologist→behavior analyst→mediator→target, remains intact.

Figure 1 illustrates the method used by the Pendleton Project in practice to carry out the treatment technique described above.

Clients are referred to a member of the Project Services Team (PST) by a participating agency, an agency of the private sector, or an individual. The PST member, who is a social worker, a probation officer, or educational specialist, collects preliminary information on the case. The referring behaviors are specified in observable terms and a record of the frequency (baseline) of these behaviors is collected for a period of one to five days. These raw data are collected by a parent or teacher or significant other who is in the child's natural environment. Other information, such as previous psychiatric, medical, or school evaluations, may be provided as well. The PST member writes a summary of this information and puts it together with other relevant documents, including a baseline chart showing the frequency of the referring behaviors. This information gathering can take one to two weeks. The PST worker then meets with the Diagnostic Team (DT) to review the case for treatment planning.

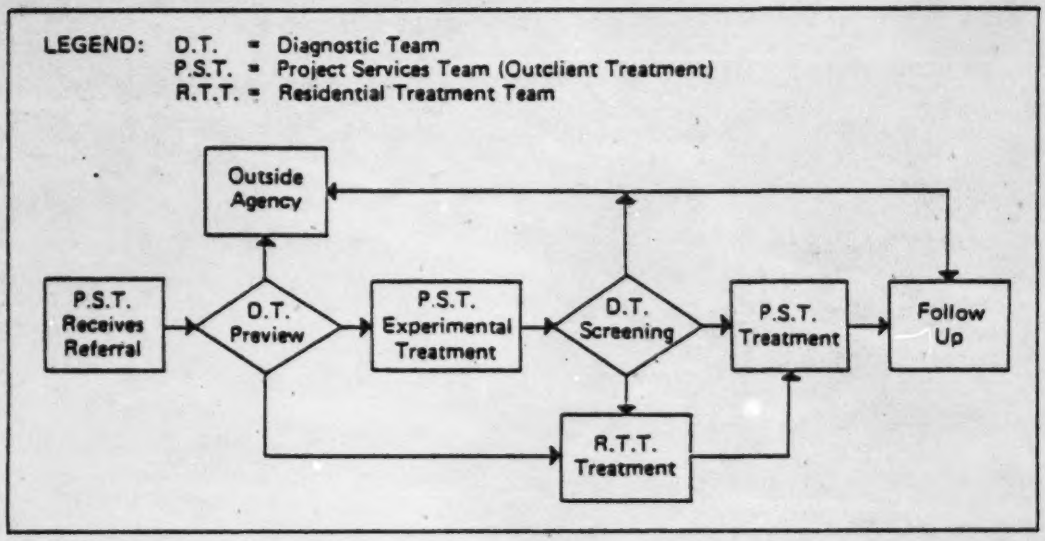

Figure 1. Pendleton Project diagnostic and treatment process alternatives.

The Diagnostic Team consists of three supervising psychologists. During the DT review, there are three options for treatment planning:

(1) The case may be appropriate to refer to another agency for service. We do not duplicate existing services. If the case can be adequately served by an existing agency, we refer the client and follow up to determine if the placement is, in fact, correcting the problem.

(2) If there are limiting circumstances in the natural environment, such a hospitalized or runaway parents, we may determine that the child should be placed in residence immediately. This is infrequent.

(3) Most often, we design a treatment plan to be carried out in the natural setting. It will be supervised by one of the psychologists and administered by the PST worker who is the behavior analyst. The procedure will be tested for at least two weeks. If the plan works, treatment will continue in the natural environment until termination. The frequencies of the referring behaviors are recorded throughout the course of treatment and follow-up. The treatment plan is regarded as working if, and only if, the frequencies of referring behaviors are within acceptable limits, as compared to the baseline

measures. Follow-up ensures that the treatment will have enduring effects. If it doesn't, the mediator is recoached until maintenance of the desired behaviors is established.

The mediator and target, and to a lesser degree the behavior analyst, are regarded as students. The program is designed to achieve specific objectives at each link in the treatment chain. The principles of learning govern the process, which I have discussed in greater detail elsewhere (Pooley, 1969).

A summary paragraph in that article states:

> Programming for learning is a straightforward and logical process. It is composed of four basic steps. (1) State the learning objectives. State them in observable terms and specify a level of minimum acceptable performance. (2) Select procedures, content, and methods relevant to the objectives. (3) Cause the student to interact with the appropriate subject matter and in accordance with the principles of learning through a systematic sequence of events which will guide the student from his current level of performance to a new level of performance stated in the terminal objectives. (4) Measure or evaluate the student's performance with respect to the prestated objectives and in accordance with an observable test criterion. (p. 20)

If the experimental phase of the outclient treatment is not working after all reasonable alternatives have been tried, then the case comes before a Diagnostic Team (DT) screening. The three options presented earlier are again considered. Sometimes the group screening will result in an outclient technique that the supervising psychologist

and behavior analyst have overlooked. If that is the case, the outclient treatment plan is revised and retested. Sometimes, however, the DT screening indicates that residential treatment is appropriate. The child is then brought into residence within five days, and the residential treatment is administered as described earlier. During the Residential Treatment Team (RTT) phase of treatment, the staff has an opportunity to work more intensively with parents and teachers, as well as with the child. The child goes home each weekend. Parents are required to provide the transportation, resulting in two meetings per week between staff and parents. Here the parents are coached in techniques that work with their child and progress is evaluated. The parents are often instructed to do some specific task with this child during the weekend and to report on the outcome when they return. This serves to increase constructive attachment between parent and child.

Teachers are asked to observe and discuss the treatment that is being given to children who will return to their classrooms. This establishes a basis for continuity of treatment when the child returns to the public school and family. When the child is ready to go home, PST outclient activity is reestablished for the purpose of gradually shifting responsibility for the treatment from the control of the Project workers to the control of the mediator. As mentioned, follow-up visits are made to ensure the maintenance of the newly established behavior patterns shown by

the child and by the mediator. More detailed examples of our methods can be found in seven volumes of the semiannual reports (e.g., Pooley, 1976a, 1976b, 1977); each report contains several case studies.

The entire process is directed toward increasing the child's attachment to the social institutions (i.e., home, school, and social order) that are likely to help the child to grow into a competent and productive citizen.

Some Factors that Interfere with Attachment

During the earlier discussion on the theoretical considerations of delinquency, the concept of attachment was briefly explored. It was suggested that a basic cause of delinquency is lack of attachment on the part of the disturbing young person to those entities that represent the established social order. We have repeatedly observed this phenomenon operating in the lives ot the people we serve. It appears to take at least two forms of behavior on the part of the parents. These forms of behavior have one element in common--that of distraction.

The first form of distracted behavior is, perhaps, the more obvious to observers of social dysfunction because it is related to poverty. The poor are necessarily so occupied with problems of survival that they have neither the time nor the energy to worry about the finer nuances of child development. Rather than being concerned with providing a caring and loving environment, they regard the child as

one more burden--one more mouth to feed. They are often overworked and usually underpaid. Both parents may work at two or more jobs, at all hours of the day and night. There may be only one parent in the family, usually the mother. It is not unusual for her to be overburdened with the job of earning a living and supporting several children. It is obvious that this situation leaves little time to attend to the emotional needs of the children. The children may resent this negligence and come to rebel against it with a variety of attention-getting, antisocial behaviors.

A subset of the poverty group consists of those who are not motivated to work for a living because they regard the opportunities available to them as demeaning. They may engage in various kinds of criminal activities or in trying to "beat the system" in other ways, such as by manipulating human service agencies for every conceivable benefit. I have observed parents who spend an astonishing amount of time and exhibit an astonishing degree of resourcefulness in these endeavors. It often appears to the observer that it would be infinitely easier to work for a living. But be that as it may, these people are not only neglecting their children but are also serving as models for them that run counter to the interests of society.

As part of the intervention, we attempt to reorganize the family's activities so that they approach their problems in a more efficient way. It is here that the interagency

character of the Pendleton Project is crucial. We have direct staff connections with all or most of the human service agencies that may be serving a family. This allows us to do a behavior analysis of the various agency functions with respect to the client. Thus we may gain control of certain reinforcing events available within the relevant agencies and use them in an efficient, coordinated manner for the benefit of the client. This approach has at least three advantages: (1) it reduces abuse of human services; (2) it structures the available agency reinforcers into an efficient and systematic treatment program for the benefit of the client; and (3) it reduces the probability of unnecessary contacts with the juvenile justice system and with other agencies.

The second set of distracted parents are those who pursue social goals to a fault. These are usually middle- or upper middle-class people who are so "on the make" for upward mobility in the professional and social world that they virtually ignore the unique emotional and educational needs of their children. They often become impatient and punitive when their children seek their attention.

These two categories define the socioeconomic spectrum that we serve and some associated behaviors. This is not to say that all our clients exhibit these behaviors to any great degree. Most of our clients do not. By the time they seek our services, they are usually very concerned about

their children. I cannot help but wonder if these distracting behaviors may have been present in the family to some degree in the past lifetime of the child who is misbehaving today. If so, it may be that the experience of distracted parents during early development can precipitate antisocial behavior patterns that do not receive attention until a child's later years. In other words, the absence of attachment may have been initiated by inadequate contact with the child during the early years of life. As a result the child may develop little or no concern for others, giving rise to an antisocial life style.

The objective of the treatment in cases such as this is to retrain both parent and child toward behavior patterns characterized by constructive transactions relevant to solving the problems of living and improving the quality of life.

The Extension of the Practice to Other Settings

There is strong evidence that the practices employed by the Pendleton Project are benefiting the localities that the Project serves. A broader objective of the Project is to help others to benefit from our methods. One effort specifically designed to contribute to Project efficiency is equally useful in other settings. That is the development of a diagnostic/prescriptive/treatment mechanism. Although work is not complete at this writing, it is appropriate to share with others our intentions and the status of the work.

Summary of the Task

Data are collected on every subject and family receiving Pendelton treatment. The data consist of 834 variables and we intend to collect these data on more than 700 subjects for analysis. This task is being accomplished in concert with a subcontract with Old Dominion University (ODU). The objective is to develop an efficient diagnostic/prescriptive/treatment mechanism.

Rationale

The underlying assumptions, evaluation designs, and statistical procedures used for this effort are reported in detail in earlier semiannual reports (Pooley, 1976a, 1976b) and an ODU Research Foundation report (Cunningham, 1976). A review and the current status of this work is presented here.

In medicine and other types of treatment programs, comprehensive studies of causes must be made to determine why specific illnesses exist. It is difficult, at best, and usually impossible, to find a consistent cure for an illness until the actual cause for that illness has been isolated and identified. The work at the Pendleton Project is based on this very simple basic premise: it is difficult or impossible to treat antisocial behaviors without some understanding of the causes of those behaviors and a scientific base for the selection of the appropriate treatment method.

Therefore, the Pendleton Project is collecting data on the background characteristics of Pendleton children and their families in order to arrive at an accurate description of each child and his or her life space. Children who share common background characteristics can be classified as to similarity of personality, background, and dysfunctional behavior. This data can then be examined to isolate and identify characteristics unique to some categories of students. These characteristics will then be examined more closely to determine if a causal relationship can be established. The treatment programs that have been most effective with the children who share certain common characteristics will then be used as prescriptive programs for-other children identified as having similar personalities, backgrounds, and disturbing behaviors. In this way a diagnostic/prescriptive/treatment mechanism may be tested.

In order effectively to treat a disorder of any sort, the practitioner must have a clear understanding of exactly what is to be treated. Only then may he or she prescribe and/or carry out the appropriate procedure(s) to correct the situation. Follow-up should be done to determine whether or not the procedure is working. If it is not, then indicated changes are made in the treatment procedure and necessary modifications are made to the diagnostic/prescriptive system.

The treatment of behavior disorders (e.g., acting out) or family dysfunction is no exception to this rule. The acting-out child engages in behaviors such as excessive fighting, defiance, property destruction, tantrums, and poor academic achievement. Accordingly, the Pendleton Project has designed a reasonable and potentially effective method of addressing the problem. Considerable attention has been given to the development of a workable diagnostic/prescriptive tool because the acting-out child "...is considered to be the most difficult of all child patients to treat" (Kay, 1976).

Method

The Pendleton Project has treated and collected data on 572 families referred to us. Similar data have been collected on a control sample (N=53). The data set is very extensive, consisting of 834 demographic, behavioral, developmental, and personality variables. These data are analyzed to accomplish three objectives: (1) to determine the characteristics that separate the treatment population from the control group, (2) to eliminate those variables that have little or no diagnostic value, and (3) to cluster the remaining variables so that they identify children sharing characteristics common to specific disturbing behaviors and treatment approach, but who are significantly different from children sharing other common characteristics and functional

or dysfunctional behaviors. Thus, discrete subgroupings are identified from a diagnostic point of view. It is not yet known how many subgroups will emerge. The next step will be to examine for similarity the treatment(s) that have been administered to each subgroup.

If effective treatment(s) are similar within each subgroup but dissimilar between subgroups, then we have an economical diagnostic/prescriptive/treatment mechanism that can be easily understood and efficiently administered. Children can be classified as to subgroup and then the treatment proven most effective for that subgroup in the past can be used.

Results

This process may enable us to develop a diagnostic questionnaire containing only those items relevant to our purpose. It is anticipated that the present 834 items can be reduced to less than 300 very powerful indicators of subgroup characteristics. When a family completes the questionnaire and it is evaluated, they then may be assigned to an appropriate category.

Clearly, this process reduces guesswork. It is very clear, and it identifies the treatment of choice very rapidly. It should also greatly increase the probability of success since, instead of choosing a treatment approach randomly, we can select one on the basis of its success with similar types of families in the past.

At present, 200 cases have been analyzed with respect to reducing the data set, and this work continues. Initial analysis has found 45 identifying characteristics which can be used to describe Pendleton children. Other reports (e.g., Cunningham, Pooley, & Eun, 1977) are available which list and describe these characteristics, which range from very simple descriptors to very complete ones. Examples of descriptors are: age, number of siblings, IQ, anxiety level, popularity, self-concept, parent and/or teacher perceptions of the child (e.g., self-centered, well-behaved, etc.), negative discipline by mother, educated stepfather with young mother, unstable low socioeconomic family, inactive child, working mother. Examples of complete descriptors of two of these categories are:

18. Unstable Low Socioeconomic Family

The child is not the youngest in the family, not a member of clubs, and is not living with the natural father. The mother is middle-aged, has been married more than once, is herself from a broken home, and has a court record. The child's younger siblings are exhibiting behavior problems. He or she is from a low-income family living in public housing and/or an urban environment. (A high score on this scale suggests these conditions exist. A low score score suggests these conditions do not exist.)

23. Active Child Disciplined Negatively by Mother and Positively by Father

Mother is considered the disciplinarian and uses negative reward or punishment such a whipping, spanking, deprivation of privileges, and scolding. Father provides positive rewards such as praising, material rewards, and earning privileges. The child engages in active play with both siblings and nonsibling playmates. (A high score indicates an active child disciplined by mother and praised by father. A low score indicates that these conditions do not exist.)

In the future, we plan to analyze 600 more cases and to identify the subgroupings of those 800 cases with respect to treatment. Then the perfromance of the reduced set of questions will be tested for diagnostic/prescriptive/ treatment effectiveness.

The results of this work will serve three purposes. First it will be used internally by the Pendleton Project and similar agencies for the treatment of children demonstrating antisocial behavior. The results will provide an effective model for the remediation and rehabilitation of these children before the antisocial behavior becomes a more serious social problem. A second use might be to provide schools with a simple diagnostic/prescriptive system for children displaying behavior problems within the school. Teachers, counselors, and principals could use the findings

within the school classrooms to try to improve student behavior. The last but certainly not the least important purpose might be to aid in the development of preventive measures. Once common causal characteristics have been identified, community education programs and materials can be developed to inform teenagers and young adults about the kind of background characteristics that can cause dysfunctional and antisocial behaviors in young children. The prevention approach might tell the parent, "If this is the kind of home-life and background you provide for your child, you are likely to be developing a behavior problem that may cause your child to be miserable and in trouble his entire life." It could point out that services designed to improve the quality of life are available at Pendleton and elsewhere. Public-service messages could be placed in newspapers and on radio and television for the purpose of community education aimed at prevention. If and when this happens on a broad scale, we shall have the purest form of community-based prevention and treatment of disturbing behaviors that this nation has ever seen.

Conclusions

My intention in this paper has been to give a concise picture of the increased disturbing behaviors shown by children and of the cost of such behaviors in terms both of dollars and of human misery. Certain diseconomies exist in the traditional approach to dealing with these problems and

innovation is indicated. An interdisciplinary treatment program called the Pendleton Project was offered as an example of innovation. Certain salient dimensions of the problem and its treatment were developed in some detail, namely, the diagnosis and treatment of learning disabilities and methods to establish attachment between the disturbing child, his family, and the social order in general. Strategies to extend innovative approaches to problem solving were presented in the discussion of the practice of behavioral treatment and research activities associated with the practice.

It is beyond the scope of this paper to discuss all the fine points one must consider when developing an innovative human service system. These details are presented in the Pendleton Project's semiannual reports (Pooley, 1974a, b, 1975b, c, 1976a, b, 1977) and are available in other documents and publications. During the American Educational Research Association's 1977 annual meeting, a symposium on the subject of treating children and families with disturbing behaviors was scheduled. Three of the papers presented there included more elaborate accounts of the Pendleton Project's outclient treatment (Shea, Pooley, & Eun, 1977), residential treatment (Eun, Pooley, & Shea, 1977) and research activities (Cunningham, Pooley, & Eun, 1977). There are some conclusions that can be drawn from our experience that are likely to be useful to others working to develop innovative treatment programs.

The first is that there is a general tendency among established bureaucracies to resist with great zeal any attempts at innovation. The reasons for this are complex and are discussed in the literature of organizational theory, management theory, political science, and other disciplines. I will discuss here a specific aspect of resistance to innovation and the main argument used to justify such resistance.

Without exception, the critics of the Pendleton Project argue against it on the basis of economics. They often focus on a single component of the Project; namely residential treatment, and conclude that the Project is too expensive. The critics stress that the Project is staffed by several highly trained professionals and a great number of direct-service professionals at a cost of nearly half a million dollars a year to serve 12 to 18 residents. Even when they do take outclient services into account, they stress that each Project caseworker maintains a caseload of perhaps 15 persons, compared with caseworkers in other settings (e.g., probation or social work) who maintain a caseload of about 70 persons. They conclude from this that the Project is too costly and top-heavy with professional staff. This conclusion is totally wrong, because these critics neglect to consider one crucial element built into the design of the Project: the flow rate of the clientele. It is the process variables and the outcome of treatment over time, rather

than caseload statistics at any one given time, that are important.

It is true that a probation officer, a social worker, or a mental health caseworker may maintain a caseload of 70 persons or more. It is also true that many residential settings serve more than 100 persons at a time. At least, they fill 100 or more beds. The question is, how many of those clients are successfully processed through these traditional systems over time? One study found that only about 13 percent of all adolescents and children who are in child-care institutions because they have been judged to be disturbed are receiving treatment (Durkin & Durkin, 1975).

It is well-nigh impossible for a single outclient caseworker to deliver adequate service to a caselaod of 70 or more troubled families. People who try to do this may process and terminate less than 10 clients per year, and many of those may reenter the system later. Many institutions which house more than 100 clients are understaffed and realistically do little more than warehousing human beings. The desirability of such a practice is certainly questionable with regard to human issues and to economical concerns as well.

On the other hand, properly planned and executed innovative approaches to human service improve not only the quality of treatment but also its efficiency. Such approaches serve more people more economically than more widely used traditional methods. Until this fact is understood and

accepted by the human service community in general, our efforts may be viewed by some with disdain. Until then Project workers must steadfastly work in a field that is difficult at best, and where extrinsic personal rewards for excellence are meager or absent. Yet there are people who are secure enough within themselves to rise to the challenge. This is an important consideration in the hiring of staff.

There is wisdom to the Pendleton Project's pattern of hiring well-trained psychologists, teachers, counselors, behavior technicians, caseworkers, and others, even though this may add to our operating expenses. The Project is designed to treat the most serious behavior disorders in a two-city, 610-square-mile area. The children referred to us very often require sustained human service over several years if early intervention has not been provided. We have demonstrated that we can treat serious behavior disorders for more than 380 cases per year. At termination, we are successful in 76 percent of the cases. One year after termination, treatment effects are sustained in 58 percent of the cases. This is accomplished by a treatment approach characterized by a small caseload, intense short-term intervention, and an integrated organization of expert and dedicated staff. There are also spin-off benefits. Many staff members are regularly involved in training other agencies in our methods. They also work in other community-education and professional training activities.

Even the most dedicated, competent, and ambitious human service workers will not be able to ply their trade in an innovative setting unless certain political realities are addressed at the outset. The planning phase of such a project must include the establishment of connections with existing bureaucracies within the human service system. The leadership of these agencies must be persuaded to accept the benefits that are likely to accrue to themselves, their organizations, and the people they serve. This is not an easy task, but it is not impossible.

During the planning phase of the Pendleton Project, and prior to hiring a single person, a planning board was formed consisting of the directors of the human service agencies at the state and local levels. Within this board emerged a core of leadership that was in agreement as to what should be done. They, together with the state Secretary of Human Affairs, worked diligently to promote understanding by and agreement of others about a course of action. A tentative plan for implementation was devised and funds were secured to begin the Project. Gradually, the Project was staffed and began to pass through the various developmental stages and experience the growing pains characteristic of a new organization. The importance of building into the Project design functional linkages with human service agencies and the political and public support associated with such linkages cannot be overstated.

This support was demonstrated at a crucial stage in the establishment of the Pendleton Project as a continuing entity. At the beginning of our fourth year, as a matter of policy, federal funding was cut in half. When this happened, State General Assembly was mobilized to pass a House Joint Resolution to provide continued support until a more permanent funding mechanism could be designed. This was tangible evidence that the state legislators were well informed on the Project benefits and clearly understood its several advantages over other agencies.

Since the inception of the Pendleton Project, we have enjoyed support in the form of a Management Board composed of the state and local leadership in human services. This entity provided us the opportunity to experiment with and develop an efficient interdisciplinary treatment program designed to address and correct disturbing behaviors in children and their families. The success of this innovation has fostered regional cooperation between agencies which serve a common population.

Evidence of this may be seen in the replication of the Pendleton multiagency concept for the delivery of human service to the elderly in Northern Virginia. In the past year, we have received requests for information from 64 localities in 31 states and two Canadian provinces. Public interest at such a level indicates that the integrity of the coordinated approach to human service presented here is becoming obvious.

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